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Supreme Court, U.S.
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In The

SUPREME COURT OF THE UNITED STATES

October Term, 1997

RANDON BRAGDON, D.M.D.

Petitioner,

v.

SIDNEY ABBOTT, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

1. Is reproduction a major life activity within the meaning of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101-12213?

2. Are asymptomatic individuals infected with HIV per se disabled within the meaning of the ADA?

3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedure on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?

PARTIES

The parties before the United States Court of Appeals for the First Circuit were appellee Sidney Abbott, appellee The Maine Human Rights Commission, and appellant Randon Bragdon, D.M.D.

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OPINIONS BELOW

The opinion of the Court of Appeals for the First Circuit is reported at 107 F.3d 934 (1st Cir. 1997) (Pet. App. 1a-30a). The opinion of the United States District Court, District of Maine, is reported at 912 F. Supp. 580 (D. Me. 1995) (Pet. App. 31a-65a).

JURISDICTION

The Appeals Court entered judgment on March 5, 1997, and denied petitioner's petition for rehearing on April 22, 1997. The petition for writ of certiorari was filed on July 21, 1997, and was granted on November 26, 1997. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The statutes and regulations directly involved in this case are 42 U.S.C. § 12101(2), 42 U.S.C. § 12182(b)(3), 28 C.F.R. § 36.104 (list of major life activities under definition of disability), and 28 C.F.R. § 36.208(c). They are reprinted in the appendix to this brief and at Pet. 1-2.

STATEMENT

1. *AIDS and HIV.* Acquired immunodeficiency syndrome (AIDS) is a condition that occurs in individuals infected with the human immunodeficiency virus (HIV). *See generally* Mitchell Katz & Harry Hollander, *HIV Infection*, Current Medical Diagnosis & Treatment 1204 (1998). AIDS is not a disease itself, but a set of

signs and/or symptoms that occur together. The "hallmark of symptomatic HIV infection is immunodeficiency." *Id.* at 1207. With immune depression, diseases that do not affect a person with a healthy immune system can be devastating. *Id.*[1]

The clinical definition of AIDS has evolved over the past decade. In 1993, the Centers for Disease Control and Prevention (CDC) expanded the definition of AIDS to include persons infected with HIV and who have ever had a CD4 lymphocyte count below 200 cells/μL or a CD4 lymphocyte percentage below 14%. *Id.* at 1204. The new definition of AIDS was also expanded to include HIV-infected persons with pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer. *Id.* The definition continues to include persons with any of a lengthy list of various opportunistic infections (e.g., pneumocystis pneumonia) and neoplasms (e.g., Kaposi's sarcoma), as well as HIV-infected persons with documented weight loss, diarrhea, or dementia. *Id.*

The "earliest stages of HIV infection may be unapparent or may be expressed in symptoms similar to those of many other viral infections, including mild fever, malaise, and swollen lymph nodes." 1 *Magill's Medical Guide: Health and Illness* 10 (1995). Diagnostic blood tests to detect HIV actually detect HIV antibodies. When an individual is infected with HIV, it can be several

[1] In addition to HIV-1, the predominate form of HIV in the United States, a group of related viruses, HIV-2, have been isolated in West African patients. *Id.*

months before the development of antibodies. During this time, a person infected with HIV may test negative, but actually be infected with HIV. *Id.* at 10-11. A "small incidence of individuals (< 1%) are infected with HIV for up to 36 months without generating an antibody response." Katz & Hollander, *supra*, at 1216.

Approximately five percent of individuals infected with HIV have "remained clinically healthy and immunologically normal for more than a decade." Yunzhen Cao, et al., *Virologic and Immunologic Characterization of Long-Term Survivors of Human Immunodeficiency Virus Type 1 Infection*, 332 N. Eng. J. Med. 201, 201 (1995). In fact, the "median interval between infection and the development of AIDS has been 10 years." Review, *HIV and Pregnancy*, 103 Br. J. Obstet. Gynaecol. 1184, 1185 (1996). Thus, "[m]any individuals with HIV remain asymptomatic for years, with a mean time of approximately 10 years between exposure and development of AIDS." Katz & Hollander, *supra*, at 1208. During this period, many asymptomatic individuals with HIV remain clinically healthy and immunologically normal. Cao et al., *supra*, at 201. As the word itself connotes, *asymptomatic* HIV infection does not substantially limit a person's ability to care for one's self, perform manual tasks, walk, see, hear, speak, breathe, learn, or work.

Famous examples in the popular culture of asymptomatic persons with HIV are basketball great Earvin "Magic" Johnson and four-time Olympic gold-medal diving champion Greg Louganis. Mr. Louganis recounts in his

autobiography what it was like to compete in the Seoul 1988 Summer Olympics, and win two gold medals in diving, knowing that he was infected with HIV. Greg Louganis, *Breaking the Surface* 3-13, 198-213 (1995). Mr. Johnson recounts in his autobiography what it was like to play in the NBA and win an Olympic gold medal in basketball, knowing he was infected with HIV. Earvin "Magic" Johnson, *My Life* 320-346 (1992).

HIV can be transmitted by percutaneous and mucocutaneous exposure to HIV-infected blood and visibly bloody fluids. Laurie Robert & David Bell, *HIV Transmission in the Health-Care Setting*, 8 Infectious Disease Clinics of N. America 319, 319-321 (1994).[2] "Percutaneous exposures" include exposures caused by puncture or cut injuries, and "mucocutaneous exposures" include mucous membrane exposures to the tissues of the eyes, nose, and throat. The occupational risk of HIV infection after percutaneous exposure to HIV-infected blood has been estimated as, on average, 0.3%. *Id.* at 324 (Appeals Court App. 177). Injury with a device visibly contaminated with the source patient's blood is a significant factor increasing the risk of infection after percutaneous exposure.[3] The occupational risk of HIV infection after a mucous membrane exposure to HIV-infected blood has been estimated as, on average, approximately 0.09%. Robert & Bell, *supra*, at 324. Cases of "transmission of HIV infection after skin exposures

[2] Reprinted in part at Pet. App. 104a-109a. Reprinted in full at Appeals Court App. 174-179.

[3] Denise Cardo, et al., *A Case-Control Study of HIV Seroconversion in Health Care Workers After Percutaneous Exposure*, 337 N. Engl. J. Med. 1485, 1488 (1997).

also have been documented," but the risk for transmission after "skin exposures, whether to intact or nonintact skin, has not been precisely quantified." Denise Cardo & David Bell, *Bloodborne Pathogen Transmissions in Health Care Workers*, 11 Infectious Disease Clinics of North America 331, 333 (1997).

CDC has confirmed HIV transmissions from a dentist to six patients (Pet. App. 111a-1 - 132a), and courts have deemed significant the risk of HIV transmission from health care workers, including a dentist, to patients, *e.g.*, *Doe v. University of Md. Med. Sys. Corp.*, 50 F.3d 1261 (4th Cir. 1995); *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993), *cert. denied*, 510 U.S. 1119 (1994); *Doe v. Washington Univ.*, 780 F. Supp. 628 (E.D. Mo. 1991). Experts agree that the risk to the dentist is greater than to the patient. (Pet. App. 137a, 139a).[4]

2. *HIV and Pregnancy.* Recent studies indicate that "pregnancy does not appear to accelerate [HIV] disease progression, except in women with symptomatic infection or low CD4 counts." Rachana Kumar, et. al., *Impact of Pregnancy on Maternal AIDS*, 42 J. Repro. Med. 429, 429, 433 (1997) (commenting that studies in developed countries have failed to corroborate that pregnancy accelerates AIDS and reduces survival time); *see also HIV and Pregnancy*, *supra*, at 1185 (pregnancy "does not seem to have any long term effect on the rate of decline [of the CD4 lymphocyte

[4] *See also* Aug. 10, 1995, deposition of Donald Marianos, D.D.S., pp. 55-58, reprinted at Appeals Court App. 212.

count]," and "the survival time of patients with AIDS was not affected by pregnancy in a small study").

Thirteen years ago the CDC recommended that counselors advise HIV-infected women "to consider delaying pregnancy until more is known about perinatal transmission of [HIV]."[5] Some states' department of health materials went further and recommended that HIV-infected women should not become pregnant.[6] The view that HIV-infected women should be discouraged from having children has been criticized in light of more recent studies and on moral and philosophical grounds.[7]

For example, authors have compared some public health officials' opinions about pregnancy and HIV-infected women, with the case of Buck v. Bell, 274 U.S. 200 (1927), in which the Court deferred to the views of respected public health officials in Virginia, that a young, mentally retarded woman should be involuntarily sterilized. Levine & Dubler, *supra* n.7, at 338. The authors point out that many women with chronic diseases, and some who are dying, choose to become

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[5] *Recommendations for Assisting in the Prevention of Perinatal Transmission of [HIV]*, 34 Morbidity & Mortality Weekly Report 721, 725 (1985).

[6] Ronald Bayer, *AIDS and the Future of Reproductive Freedom*, 68 Milbank Q. 179 (1990).

[7] *See, e.g.*, Taunya Banks, *The [ADA] and the Reproductive Rights of HIV-Infected Women*, 3 Tex. J. Women & L. 57 (1994); Carol Levine & Nancy Dubler, *Uncertain Risks and Bitter Realities: The Reproductive Choices of HIV-infected Women*, 68 Milbank Q. 321 (1990); John Arras, *AIDS and Reproductive Decisions*, 68 Milbank Q. 353 (1990).

pregnant, even at considerable risk to themselves, or offspring, and they are more treasured for doing so. *Id.* at 323 (citing the popular film *Steel Magnolias* as a celebration of this theme).

Current studies show that the risk of HIV transmission from infected mother to child is approximately 8% if the pregnant woman undergoes AZT therapy, and approximately 25% otherwise. *HIV and Pregnancy*, *supra*, at 1186-87. (J.A. 52-53)

CDC has issued revised recommendations for counseling HIV-infected women. *Recommendations for [HIV] Counseling and Voluntary Testing for Pregnant Women*, 44 Morbidity & Mortality Weekly Report, No. RR-7 (July 7, 1995). They state that reproductive counseling for HIV-infected women should be "nondirective." *Id.* at 10. Health-care providers "should be aware of the complex issues that HIV-infected women must consider when making decisions about their reproductive options and should be supportive of *any* decision." *Id.* (emphasis added).

3. *This Case and Proceedings Below.* On September 16, 1994, respondent Sidney Abbott arrived at the private dental office of petitioner Randon Bragdon, D.M.D., in Bangor, Maine, for an appointment. On her patient registration form, Ms. Abbott indicated that she was infected with HIV. (J.A. 50) Ms. Abbott was asymptomatic at the time. (J.A. 10, 14, 49-50)

Ms. Abbott was brought into the treatment area and seated in a dental chair. Dr. Bragdon

performed a routine, diagnostic dental examination and discovered that she had a cavity near the gum line on a back, lower tooth. He told her that, pursuant to his infectious disease policy, he would not fill the cavity in his office, but would fill it in a hospital setting. Ms. Abbott said she would think about it and get back to him. (Pet. App. 80a)[8]

Ms. Abbott thereupon sued Dr. Bragdon in the United States District Court, District of Maine ("District Court") for disability discrimination under title III of the Americans with Disabilities Act (ADA). Title III prohibits discrimination by private entities in places of public accommodation.

Ms. Abbott originally argued that the *only* relevant fact about her condition is "that she's HIV positive." (J.A. 12) Her attorney instructed her not to answer any question that would reveal anything about her individual medical history. (J.A. 13) Later, Ms. Abbott took the position that she is disabled also "because she decided not to have children because of the risk of transmitting HIV to her child," *Mot. for S.J.* at 21 (Sept. 19, 1995). (J.A. 14)

Dr. Bragdon argued that Ms. Abbott was not disabled under the ADA, and even if she were, he was under no legal obligation to fill her cavity in his office because, in his judgment, the invasive procedures necessary to do so would have posed a direct threat to the health and safety of others, including himself. *See* 42 U.S.C. § 12182(b)(3).

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[8] Ex. E of Def.'s Sept. 19, 1995, Statement of Material Facts.

The District Court ruled that Ms. Abbott was disabled. It said the "position taken by [Dr. Bragdon] is not an unreasonable one," but granted summary judgment for Ms. Abbott because Dr. Bragdon failed to demonstrate that affidavits of Donald Marianos, D.D.S., M.P.H., of CDC, were "medically unsupportable." (Pet. App. 51a, 63a)

The United States Court of Appeals for the First Circuit (the "Appeals Court") explained that the question of whether reproduction is a major life activity for purposes of the ADA "is very close," but in its opinion, reproduction and "the bundle of activities that it encompasses" are major life activities under the ADA. (Pet. App. 7a, 11a) The Appeals Court implied that on the basis of legislative history, it was prepared to rule in the alternative that all asymptomatic individuals infected with HIV are disabled. (Pet. App. 15a)

With respect to the issue of direct threat, Dr. Bragdon argued that it was unfair and contrary to law to defer to the affidavits of Dr. Marianos when they post-date Ms. Abbott's appointment and contain opinions absent and different from views expressed in official, published CDC materials. Dr. Bragdon also argued that courts should defer to private health care providers' judgments, as long as they are reasonable in light of then-current medical knowledge.

The Appeals Court partially disagreed with respect to the Marianos affidavits, noting they are of "limited value." (Pet. App. 23a n.7) The Appeals Court completely disagreed with respect to the question of deference, granting a continuing

presumption of correctness to conclusions which it said "seem to be implicit" (Pet. App. 23a) in *Recommended Infection-Control Practices for Dentistry, 1993*, 41 Morbidity & Mortality Weekly Report, No. RR-8 (Pet. App. 181a-199a). The seemingly implicit conclusions identified by the Appeals Court are that no further risk-reduction measures are desirable for dental workers when treating HIV-infected patients than those measures recommended by CDC for all patients, and that filling cavities of patients known to be infected with HIV is generally safe. (Pet. App. 23a)

After reviewing the record, the Appeals Court affirmed summary judgment for Ms. Abbott, deciding that Dr. Bragdon failed to raise a genuine issue of fact by presenting sufficient countervailing evidence to rebut the presumption of correctness attached by it to the seemingly implicit CDC conclusions.

4. *The Dispute Over Direct Threat.* The parties disagree about the nature and significance of the risk of transmission of HIV from a patient, such as Ms. Abbott, to a dentist, such as Dr. Bragdon, while performing procedures necessary to fill a cavity on a back lower tooth, near the gum line. The parties also dispute the significance of the risk of active tuberculosis (TB) in HIV-infected individuals, and what are reasonable precautions that a dentist may take while performing cough-inducing and aerosol-generating procedures on *all* HIV-infected individuals. (Pet. App. 152a-154a)

Dr. Bragdon's understanding is that the Court does *not* intend to consider whether, in this

particular case, Dr. Bragdon raised a genuine factual issue for trial as to whether his judgment on September 14, 1994, was within a range of reasonable professional judgment, given then-current medical knowledge.[9] The Court appears to have indicated, instead, that it will consider the purely legal question of whether, *assuming* a private health care provider makes a reasonable professional judgment, may he nonetheless be liable under title III of the ADA for disability discrimination on account of conflicting implicit views of one or more public health officials.

If this is true, and if the Court rules that deference should be given to the reasonable judgments of private health care providers, or that the legal presumption applied against Dr. Bragdon by the Appeals Court is otherwise erroneous, then the Court can, and presumably will return the case to the lower courts for application of the correct legal standard, and a decision under it of whether Dr. Bragdon raised a genuine issue for trial, or whether either party should prevail by summary judgment. To the extent, then, that this is the posture of the case, there is no reason for Dr. Bragdon to detail the evidence summarized in his petition for writ of certiorari, pages 13-22, supporting the conclusion that he made a reasonable, professional judgment of direct threat.[10]

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[9] Dr. Bragdon's understanding is based on the Court's limited grant of certiorari which excluded petition Question 5.

[10] Dr. Bragdon does reserve the right to brief these factual issues in reply. Dr. Bragdon's basis for concern is that Ms. Abbott's Rule 26 designation of additional parts of the record to be included in the joint appendix, and her counsel's

SUMMARY OF ARGUMENT

1. Actual "disability" under the ADA is defined as an impairment that substantially limits one or more major life activities. The regulation's examples of major life activities are caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Asymptomatic individuals infected with HIV are not in any ordinary sense substantially limited in the ability to care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, or work. Many with HIV would take offense at the blanket assumption they are disabled, and be critical of those who confound AIDS and HIV infection. The ADA itself is designed to prevent such false presumptions. Asymptomatic HIV-infection is therefore *not* per se an actual disability under the ADA.

2. Proponents of the view that all asymptomatic HIV-infected individuals are disabled under the ADA rely on two arguments.

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statements to the undersigned when questioned about that designation, indicated a preliminary intent to argue before the Court facts pertaining to the quantitative and qualitative risk of transmission of HIV and TB to dentists. Dr. Bragdon also anticipates the possibility of many well-meaning *amicus curiae* briefs which will argue facts relating to direct threat. For these reasons, Dr. Bragdon is compelled to reserve his rights on this issue, and will reassess after reviewing the opposition briefs, whether it is necessary to argue any evidentiary details supporting the reasonableness of his judgment and the existence *vel non* of a direct threat in this case.

The first argument is that all asymptomatic HIV-infected individuals are actually disabled because HIV infection is a physical impairment that substantially limits their intimate sexual relations and/or ability to reproduce. This argument is without merit for several reasons. *First*, as to medical fact, the argument is incorrect, even for women of child bearing age. Asymptomatic HIV-infection is not a substantial *physical* limitation on their ability to have intimate sex and/or reproduce. *E.g.*, Kumar, et. al., *supra*, at 433. *Second*, the argument confuses moral decision-making for physical disability. Asymptomatic HIV-infected women of child bearing age make different culturally and morally informed decisions concerning sex and pregnancy, but that does not make some disabled, and others not. *Third*, sexual intercourse without barrier protection and/or reproduction are not major life activities for the purpose of defining disability under the ADA.

The second argument that all asymptomatic HIV-infection individuals are disabled is that the legislative history says they are. This argument is without merit because the definition is plain that there are no per se disabilities. Even if it were not, the legislative history repeatedly equivocates on whether all asymptomatic individuals with HIV are disabled under the ADA. Members of Congress can have no reasonable expectation that courts will elevate portions of committee reports and floor debates to the status of a statute when the reports and statements do violence to the plain wording of the statute on a politically difficult issue, and when they are based on false presumptions concerning the physical effects of HIV.

3. When people at random are asked whether reproduction is a major life activity, many, especially those raising small children, say it is. Many without children believe it is not. The role of the Court, however, is not to poll the man in the street, nor to defer to its own first reactions, either way. The role of the Court is to look at the object and policy of the ADA as a whole. When it does, the Court will find that the focus of the ADA is on public, not private family life. The Court will conclude that it is neither coincidence, nor forgetfulness, that specifically reproductive disorders are never discussed or treated as disabilities, and that sexual activity and reproduction never appear on Congressionally approved regulatory lists of major life activities.

4. The most sensible decision for the Court is that a currently asymptomatic person infected with HIV is disabled *if* a would-be defendant regards the infection as substantially limiting in a pertinent major life activity, or *if* the HIV has caused the person to have a record of substantial limitation in a major life activity. In other words, many HIV-infected persons, including those without symptoms, will be protected under the ADA, but asymptomatic HIV infection is not automatically a disability.

5. Between 1984 and Ms. Abbott's September 16, 1994, dental appointment, Dr. Bragdon participated in approximately 32 professional continuing education courses relating to infection control, HIV, and/or treatment of persons with HIV

and AIDS.[11] On September 16, 1994, he made what he thought was a reasonable professional judgment based on, *inter alia*, CDC reports of HIV transmission in the dental setting, CDC reports of occupational transmission of HIV to health care workers, and his ethical obligation to fill his patient's cavity.

If Dr. Bragdon made a reasonable professional judgment, he should not be liable for disability discrimination under title III, and especially not on the basis of what merely seems implicit in CDC guidelines.

Consistent with title III regulations, if Ms. Abbott is disabled, the Court should remand for a factual determination as to whether Dr. Bragdon's judgment was within a reasonable professional range, given then-current medical knowledge. If the real dispute is over public health value tradeoffs given a small, but identifiable risk to dentists such as Dr. Bragdon, then Dr. Bragdon should not be liable if he acted in good faith, and a reasonable dentist in his shoes could deem the risk personally significant. In other words, the Court should not impute to Congress the intent to abrogate private professional judgments, and to compel health care workers to take personally significant risks, on the basis of non-committal health authority guidelines. The police power of the State includes the power to compel citizens to take risks, but this should be done by express legislation, or formal rulemaking, where relevant

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[11] Third Affidavit of Randon Bragdon ¶¶ 2-3 (Oct. 19, 1995), filed in the District Court on October 20, 1995.

facts and value tradeoffs can be articulated and debated.

ARGUMENT

I. THE PLAIN WORDING OF THE ADA SHOWS THAT HIV INFECTION IS NOT A PER SE DISABILITY.

A cardinal canon of statutory interpretation is that "courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992); *see TVA v. Hill*, 437 U.S. 153, 173 (1978) (courts may not ignore plain language in a statute); *cf. Southeastern Community College v.* Davis, 442 U.S. 397, 405 (1979) (starting point for construction of a statute is always the language itself).

The ADA says that an individual may be disabled in one of three senses. An individual is actually disabled if the individual has a "physical or mental impairment that substantially limits one or more major life activities." 42 U.S.C. § 12102(2)(A). An individual is also disabled if the individual is not currently limited in a major life activity, but either has a record of an impairment substantially limiting a major life activity, or is regarded as having an impairment substantially limiting a major life activity. 42 U.S.C. § 12102(2)(B) & (C).

In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), the Court considered a virtually identical, three-prong definition of handicapped for

use in section 504 of the Rehabilitation Act of 1973 (the "Rehabilitation Act").[12] The Court granted certiorari in *Arline* on whether tuberculosis (TB) is a handicap under the Rehabilitation Act, and the Eleventh Circuit opinion under review loosely seemed to indicate that *all* people with TB are handicapped. *See Arline v. School Bd. of Nassau County*, 772 F.2d 759, 763 (11th Cir. 1985); Tr. of Oral Arg. 28-29 (No. 85-1277) ("Q: [O'Connor, J.,] . . . as I understand it, the Eleventh Circuit held that all people with tuberculosis are handicapped"). Ms. Arline's brief also suggested that TB is per se a handicap. *See* Resp't Br. at 12 (No. 85-1277).

At oral argument Ms. Arline conceded that not all people with TB are handicapped. Tr. of Oral Arg. 29 ("Q: [O'Connor, J.,] . . . Do you agree with me, then, that not all people with tuberculosis are handicapped? A: I certainly agree"). Petitioners conceded that Ms. Arline *was* handicapped because of her record of hospitalization on account of the debilitating effects of TB. Tr. of Oral Arg. 12, 17, 52-53; J.A. 11 (testimony that Ms. Arline had a record of being hospitalized on account of the acute effects of TB on her respiratory system).

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[12] ADA regulatory guidelines and legislative history specifically endorse the Department of Health, Education, and Welfare's (HEW's) analysis of "individual with a handicap" in HEW's regulations, 42 Fed. Reg. 22676, 22685 (May 4, 1977), implementing § 504. *See* 28 C.F.R. Pt. 36, App. B § 104 (citing 1977 HEW regulations and ADA House Educ. and Labor Comm. Rep. at 50). The term "disability" now replaces the term "handicap" in the Rehabilitation Act, 29 U.S.C. § 706(8)(B).

The Court thereupon framed the question as whether persons with TB, a contagious disease, *may* be handicapped under the Rehabilitation Act. *Arline*, 480 U.S. at 275. The Court held that they may, and found that Ms. Arline was handicapped because of her record of an impairment substantially limiting a major life activity. *Arline*, 480 U.S. at 281. Implicit in the Court's decision is that TB, a contagious disease, is not always a handicap, and that an individual with TB is not handicapped under the first prong of the definition unless she has a physical or mental impairment that substantially limits a major life activity.

The same analysis applies to HIV. HIV infection is not automatically a disability. When it substantially limits a major life activity, it is. When it is asymptomatic, it is not a disability, unless there is a record of substantial limitation of a major life activity, or the would-be defendant regards the infection as substantially limiting in a pertinent major life activity. *See Ennis v. National Ass'n of Bus. & Radio, Inc.*, 53 F.3d 55, 59-60 (4th Cir. 1995) (HIV infection is not per se a disability, and the "plain language of [42 U.S.C. § 12102(2)] requires that a finding of disability be made on an individually-individual basis").[13]

[13] Some immunologic defects caused by HIV are "explained not by *quantitative* abnormalities of lymphocyte subsets but by *qualitative* defects in CD4 responsiveness induced by HIV." Katz & Hollander, *supra*, at 1207. If an asymptomatic HIV-infected plaintiff does not, however, present any evidence of the HIV's detrimental physical impact on her, either quantitatively or qualitatively, then she cannot properly be found even to have a "physical impairment." *See Runnebaum v. Nationsbank of Md., N.A.*, 123 F.3d 156, 169-70 (4th Cir. 1997) (en banc) (asymptomatic HIV-infected plaintiff failed to show that the HIV-infection was an impairment). Ms. Abbott did not introduce any evidence as to a quantitative or qualitative impairment of her immune system. For that reason, summary judgment for Dr. Bragdon is appropriate.

The Court should not go beyond the plain language of 42 U.S.C. § 12102(2), in order to decide that HIV, like any other virus or condition, is not per se a disability, and that a plaintiff with HIV is not disabled under 42 U.S.C. § 12102(2)(A) unless she demonstrates that she has a physical or mental impairment that substantially limits a major life activity.

II. LEGISLATIVE HISTORY DOES NOT ESTABLISH THAT HIV-INFECTION IS A PER SE DISABILITY.

The Senate Labor and Human Resources Committee Report on the definition of disability under the ADA (the "ADA Senate Report") states: "It is the Committee's intent that the analysis of the term 'individual with handicaps' . . . by the Department of Housing and Urban Development [HUD] of the regulations implementing the Fair Housing Amendments Act of 1988 apply to the definition of the term 'disability' included in this legislation." S. Rep. No. 101-116, 101st Cong., 1st Sess. 21 (1989).

The HUD regulations implementing the Fair Housing Amendments Act of 1988 (the "1988 Act") specifically discuss the question of whether persons infected with HIV "are understood to be persons with a 'handicap' protected by the Act." 54 Fed. Reg. 3232, 3245 (Jan. 23, 1989). The

HUD regulations refer to *Arline* and to many statements in the 1988 Act's legislative history indicating that HIV-infected persons are protected. "In light of these authorities," HUD says, it "has added [HIV] to the illustrative list of 'physical or mental impairments' in the final rule's definition of handicap." *Id.* "Physical or mental impairments" are distinct from "handicaps" in the 1988 Act's definition of "handicap", 42 U.S.C. § 3602(h), just as "physical or mental impairments" are distinct from "disabilities" in the ADA's definition of "disability," 42 U.S.C. § 12102(2). Physical or mental impairments of any kind are not handicaps or disabilities unless and until they also substantially limit a major life activity. The HUD analysis, therefore, plainly stops short of defining HIV as a per se handicap. HUD recognizes HIV as an impairment, but not as a handicap. This analysis of HIV infection comports with the Court's analysis in *Arline*, with the medical fact that not all HIV-infected persons are substantially limited in a major life activity, and with the plain wording of the 1988 Act.

The ADA Senate Report explicitly endorses this HUD analysis. According to this legislative history, HIV infection is not per se a disability, but rather one example among many of a physical impairment that may, in appropriate circumstances, trigger a disability.

Like the ADA Senate Report, the ADA House Education and Labor Committee, Judiciary Committee, and Energy and Commerce Committee Reports all explicitly endorse this HUD analysis which recognizes HIV as an impairment, but not as

a handicap. The Education and Labor Committee Report states: "It is the Committee's intent that the analysis of the term 'individual with handicaps' . . . by the Department of Housing and Urban Development of the regulations implementing the Fair Housing Amendments Act of 1988 (54 Fed. Reg. 3232 *et seq.* (Jan. 23, 1989)) apply to the definition of the term 'disability' included in this legislation." H. Rep. No. 101-485(II), 101st Cong., 2d Sess. 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 332.[14]

Like the ADA Senate Report, these sources of legislative history also treat HIV as an impairment that may trigger a disability, but not a per se disability.

Ms. Abbott will point out that the ADA Senate Report also states: "As noted by the U.S. Department of Justice, 'Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals,' September 27, 1988, at 9-11, a person infected with [HIV] is covered under the first prong of the definition of the term 'disability.'"

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[14] The Judiciary Committee Report states that the "Committee intends that the analysis of . . . the term 'handicap' contained in the primary regulations implementing the Fair Housing Amendments Act of 1988, apply to the definition of 'disability' in the ADA." H. Rep. No. 101-485(III), 101st Cong., 2d Sess. 26-27, *reprinted in* 1990 U.S.C.C.A.N. 445, 449. The Energy and Commerce Committee Report states that the definition of disability in the ADA is intended to have "the same meanings given to the corresponding provisions used in the definition of . . . the term 'handicaps' in section 802(h) of the Fair Housing Act, and in regulations issued under those statutes." H. Rep. No. 101-485(IV), 101st Cong., 2d Sess. 36, *reprinted in* 1990 U.S.C.C.A.N. 512, 525.

S. Rep. No. 101-116, 101st Cong., 1st Sess. 22 (1989).

The Justice Department document to which the ADA Senate Report refers is a memorandum prepared for Arthur B. Culvahouse, Jr., then Counsel to the President, by then acting Assistant Attorney General Douglas Kmiec (the "Kmiec Memorandum"). The Kmiec Memorandum does not purport to be a definitive interpretation of the Rehabilitation Act, but instead offers predictions on how courts will rule on the question of whether asymptomatic persons with HIV are handicapped. *See Runnebaum v. Nationsbank of Md., N.A.*, 123 F.3d 156, 170-71 (4th Cir. 1997) (en banc).

The Kmiec Memorandum notes that "*Arline* did not resolve the application of section 504 to *asymptomatic* HIV-infected individuals," and that asymptomatic persons with HIV do not seem to be disabled in the normal sense of the word. Kmiec Memorandum § II.B, pp. 6, 9. The Memorandum nonetheless predicts that courts will decide that asymptomatic HIV-infected persons are substantially limited in procreation and intimate personal relations. *Id.* § II.B.2, pp. 9-11.[15]

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[15] Two years earlier, then Assistant Attorney General Charles Cooper, writing for the Justice Department, stated: "Which brings us to the central proposition of our analysis: that persons who are infected with [HIV] but have no symptoms of the disease are not handicapped [under the first prong of the definition of handicap for use in § 504]." Charles Cooper, Office of Legal Counsel, U.S. Dep't of Justice, *The Justice Department's Perspective*, Legal, Medical and Governmental Perspectives on AIDS as a Disability 16, 17 (1987).

The significance of the ADA Senate Report reference to the Kmiec Memorandum is not entirely clear. To the extent it signifies the Committee's belief that asymptomatic HIV is always a disability, it contradicts the Committee's simultaneous endorsement of the HUD approach, which specifically recognizes HIV as a physical impairment, but not a handicap per se.

This pattern of conflicting HUD and Kmiec Memorandum endorsements repeats itself in the ADA House Education and Labor Committee and Judiciary Committee Reports. For example, two pages after endorsing the HUD analysis, the House Education and Labor Committee Report states: "As noted by the U.S. Department of Justice, 'Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals,' September 27, 1988, at 9-11, a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." H. Rep. No. 101-485(II), 101st Cong., 2d Sess. 52, 1990 U.S.C.C.A.N. 303, 334.[16] Statements by several individual members of the House and Senate on the floor of Congress also seem to treat HIV as a disability per se.[17]

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[16] *See also* H. Rep. No. 101-485(III), 101st Cong., 2d Sess. 29 n.18, *reprinted in* 1990 U.S.C.C.A.N. 445, 451.

[17] *E.g.*, 136 Cong. Rec. H4621 (July 12, 1990) (Rep. Dannemeyer) ("The American people have no idea that with the adoption of this act we are instantaneously going to bring within the definition of disabled person across this land every HIV carrier in America"); *id.* at H4626 (Rep. Waxman) ("All such individuals [from asymptomatic HIV infection, to symptomatic HIV infection] are covered under the first prong of the definition of disability in the ADA."); *id.* at S9694 (July

What should the Court make of these conflicting signals in the legislative history?

One answer is nothing. The wording of the definition is plain there are no "per se" disabilities. There is no justification for relying on the legislative history.

However, even if the statute were in pertinent part ambiguous, there is still no solution in the legislative history. This is because the relevant history is seriously conflicting, so that to rely on one part (e.g., endorsements of the Kmiec Memorandum) to the exclusion of another (e.g., endorsements of the HUD approach) would be like "'looking over a crowd and picking out your friends.'" Patricia M. Wald, *Some Observations on the Use of Legislative History in the 1981 Supreme Court Term*, 68 Iowa L. Rev. 195, 214 (1983) (quoting Judge Leventhal); *see Atherton v. FDIC*, ___ U.S. ___, ___, 117 S.Ct. 666, 676 (1997) (O'Connor, J., concurring) (joining in the Court's opinion "except to the extent that it relies on the notably unhelpful legislative history" that is "as the majority recognizes, 'not all on one side.'"); *Public Citizen v. Department of Justice*, 491 U.S. 440, 471 (1989) (Kennedy, J., concurring) (improper to disregard plain language on the basis of "fairly confident" reading of legislative history).

Ms. Abbott may argue that the numerous endorsements of the HUD regulations in the

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13, 1990) (Sen. Armstrong) ("the legislative history of this bill makes clear that infection with the AIDS virus—even in the absence of any disabling symptoms—is a covered disability").

Committee reports do not create a serious conflict because of the numerous, more explicit references, supporting the view that HIV is a per se disability. This argument is blatantly "picking out your friends." More fundamentally, it fails to appreciate how important committee reports get drafted on politically controversial issues.

On politically controversial issues, legislators' staff members carefully review report language, "suggesting changes, and negotiating compromises." Stephen Breyer, *On the Uses of Legislative History in Interpreting Statutes*, 65 S. Cal. L. Rev. 845, 857 (1992). In this instance, for "three weeks Democratic and Republican Senate staff worked intensely with the administration, the disability community, and the business community to develop [the ADA Senate Report] that established an accurate historical record reflecting the *various negotiated agreements*." National Council on Disability, *Equality of Opportunity--The Making of the Americans with Disabilities Act* 120 (1997) (emphasis added).

It is therefore virtually certain that the drafters of the ADA Senate Report, which is the model for the ADA House Reports, understood perfectly that the HUD regulations they were citing, 54 Fed. Reg. 3232, 3245, do not deem HIV a per se handicap. Thus, the most plausible explanation for the inconsistency in the ADA Committee Reports is that the negotiated political price for including statements that asymptomatic HIV is a disability, was express endorsements of the HUD regulations

issued six months earlier, which treat HIV as an impairment and not a disability.[18]

We will never know if this is what happened. Deposition of those who drafted the ADA Senate Report, even if permitted, would likely substitute disagreement over historical fact for surmise over conflicting language.

What is clear concerning the decision whether HIV is a per se disability is that a move from reliance on the statute to reliance on legislative history is a move from what is arguably plain and in accord with common sense (that a person with HIV is actually disabled only if she demonstrates she is substantially limited in a major life activity), to what is less plain and logically unsupportable (that all asymptomatic persons with HIV are substantially limited in a major life activity).[19] The Court should therefore decline the invitation to

[18] The ADA Senate Report further states that the Presidential Commission on HIV recommended that all "persons with symptomatic or asymptomatic HIV infection should be *clearly included* as persons with disabilities." S. Rep. 101-116, 101st Cong., 1st Sess. 19 (emphasis added). Congress rejected this recommendation. HIV infection is nowhere mentioned in the legislation passed after extensive debate. So visible was this issue that it is unreasonable to attribute the omission to a drafting error. The more likely explanation is that the ADA would not have passed if it contained a special provision that all asymptomatic persons with HIV are disabled.

[19] Exhibit B of the American Dental Association's *amicus* brief for the Appeals Court is a copy of an April 12, 1996, letter from four senators who supported the ADA, *see* 136 Cong. Rec. S9695, and who now favor a policy of "retaining *non-disabled* HIV-positive service members" (emphasis added). This shows that even Senators who supported the ADA do not believe that all persons with HIV are disabled.

elevate parts of the legislative history which treat HIV as a disability per se to the status of the statute. *Cf.* John F. Manning, *Textualism As a Nondelegation Doctrine*, 97 Colum. L. Rev. 673 (1997); Note, *Why Learned Hand Would Never Consult Legislative History Today*, 105 Harv. L. Rev. 1005 (1992).[20]

III. SEXUAL INTERCOURSE AND REPRODUCTION ARE NOT MAJOR LIFE ACTIVITIES ENVISIONED BY THE ADA.

A. The Theory That Sexual Intercourse and Reproduction Are Major Life Activities Is Contrary to the Focus and Purpose of the ADA.

The Court has "[o]ver and over . . . stressed that '[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.'" *United States Nat'l Bank of Or. v. Independent Ins. Agents of N. America, Inc.*, 508 U.S. 439, 455 (1993) (quoting *United States v. Heirs of Boisdore*, 8 How. 113, 122 (1849)); *see Securities and Exchange Comm'n v. C. M. Joiner Leasing Corp.*, 320 U.S. 344, 350-51 (1943) ("courts will construe the details of an act in conformity with its dominating general purpose").

[20] If scientists had found a cure for AIDS four weeks after passage of the ADA, or find a cure four weeks from today, what sense would it make to treat HIV as an actual disability based on legislative history? A finding of disability under the ADA will always require an individualized inquiry into whether a plaintiff satisfies any of the three prongs of the definition.

The ADA states that its goal is to provide a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," and to provide "clear, strong, consistent, enforceable standards addressing [such] discrimination." 42 U.S.C. § 12101(b)(1) & (2). The ADA Senate Report and all House Reports further provide that the purpose of the ADA is to "to bring persons with disabilities into the economic and social mainstream of American life." S. Rep. 101-116, 101st Cong., 1st Sess. 2.[21]

The ADA finds that discrimination denies persons with disabilities "the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity"; that people with disabilities are "severely disadvantaged socially, vocationally, economically, and educationally"; and that individuals with disabilities continually encounter discriminatory effects of "architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing

[21] *See* H. Rep. 101-485(I), 101st Cong., 2d Sess. 24, *reprinted in* 1990 U.S.C.C.A.N. 267, 268 (the ADA "will permit the United States . . . to welcome individuals with disabilities fully into the mainstream of American society"); H. Rep. 101-485(II), 101st Cong., 2d Sess. 22, *reprinted in* 1990 U.S.C.C.A.N. 303, 304 (the purpose of the ADA is "to bring persons with disabilities into the economic and social mainstream of American life"); H. Rep. 101-485(III), 101st Cong., 2d Sess. 23, *reprinted in* 1990 U.S.C.C.A.N. 445, 446 (same); H. Rep. 101-485(IV), 101st Cong., 2d Sess. 23, *reprinted in* 1990 U.S.C.C.A.N. 512, 512 (same).

facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities." 42 U.S.C. § 12101(a)(5),(6), and (9).

These purposes and findings are broad, but when they are read in context no unbiased reader would think Congress was contemplating the obstacles faced by persons suffering from reproductive disorders, such as impotence and infertility.[22] The Appeals Court's amorphous concept of "[r]eproduction (and the bundle of activities it encompasses)" (Pet. App. 11a) is also antithetical to the ADA's intent to provide "*clear* . . . enforceable standards." 42 U.S.C. § 12101(b)(2) (emphasis added).

The list of privately owned public accommodations subject to title III includes hotels, restaurants, bars, other establishments serving

[22] Impotence, also called erectile disorders, refers to a male's inability to attain or maintain penile erection sufficient to complete intercourse. *See Professional Guide to Diseases* 1004 (5th ed. 1995). Causes of male infertility include semen disorders, abnormal sperm, trauma to testes, and endocrine imbalances. *Id.* at 1010-1011. Causes of female infertility include anovulation and uterine abnormalities. *Id.* at 932-33. Impotence and infertility are to genital intercourse and reproduction as blindness is to seeing: namely, if sexual intercourse and reproduction are major life activities under the ADA, then impotence and infertility are as clear examples of actual disability as total blindness. Likewise, if an asymptomatic HIV-infected woman is disabled because of limits on her ability to have sex and reproduce, when she is able to have sex and reproduce, then impotent and infertile persons, who are actually unable to have sex and reproduce, are obviously disabled.

food and drink, motion picture houses, stadiums, lecture halls, other places of public gathering, bakeries, grocery stores, clothing stores, other sales establishments, laundromats, gas stations, travel services, shoe repair services, other service establishments, terminals, other stations used for public transportation, museums, libraries, parks, other places of recreation, schools, senior citizen centers, gymnasiums, golf courses and other places of exercise and recreation. 42 U.S.C. § 12181(7).

This lengthy list of places *is* the "mainstream of American life" into which title III wants to bring persons with disabilities. It is difficult to imagine how it would have been intended that persons with reproductive disorders needed protection to get them into this mainstream, when they have no special difficulty in going to restaurants, clothing stores, gas stations, libraries, bowling alleys, and so forth.[23] Also telling is that nowhere in the ADA's long legislative history does anyone refer to persons with reproductive disorders as a class of individuals deprived of economic and social

[23] The term "auxiliary aids and services" for use in all five titles of the ADA is defined as "qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments," "qualified readers, taped texts, or other effective methods of making visually delivered materials available to individuals with visual impairments," "acquisition or modification of equipment or devices," and "other *similar* services and actions." 42 U.S.C. § 12102(1) (emphasis added). Such aids and services have no obvious application as applied to persons with reproductive disorders.

integration into public life, and therefore covered by the ADA.[24]

The purpose of title III of the ADA, therefore, is not to facilitate sexual activity, to encourage pregnancy, or to prevent discrimination based on an inability to have sex or reproduce.[25] The purpose is to bring persons into the mainstream of American economic and civic life. Congress simply did not envision impotence and infertility, or the decision not to engage in intimate sexual relations or to raise a family, as physical or mental disabilities under the ADA.[26]

[24] Typical is the statement that the ADA is about "the 2 million Americans with mental retardation, the 15.5 million Americans with severe physical functional limitations, or the 24 million Americans with speech, language, or hearing disabilities, those with spinal cord injuries, those with head injuries, those who are blind and deaf or who have multiple sclerosis, or muscular dystrophy, or cerebral palsy." 136 Cong. Rec. H4615-H4616 (Rep. Bartlett) (July 12, 1990).

[25] The Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k), prohibits discrimination based on pregnancy, on the potential to become pregnant, *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 198 (1991), and on the inability to become pregnant, *Erickson v. Board of Govs. Of State Colleges and Univs. for N.E. Ill. Univ.*, 911 F. Supp. 316, 320 (N.D. Ill. 1995).

[26] The ADA excludes from the definition of disability "compulsive gambling, kleptomania, or pyromania" and "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders." 42 U.S.C. § 12211(b). Ms. Abbott may argue these exclusions imply Congress' underlying assumption that sex and reproduction are major life activities for defining disability. Rather than implying anything about Congress' reasoned analysis of the three-prong definition of disability, this list more likely evinces Congress' lack of concern for the specifics of the definition, confusion as between impairments and

B. The Theory That Sexual Intercourse and Reproduction Are Major Life Activities for Defining Disability Is Contrary to the Meaning of Disability in Influential Documents Presented to Congress to Promote Passage of the ADA and Other Contemporaneous, Influential Studies Of Disability in America.

The House Conference Report on the ADA explains that the National Council on Disability (formerly the National Council on the Handicapped) was "the impetus, force, and originator of the initial legislation for the [ADA], reflected in the Council's report, 'Toward Independence,' published in February, 1986." H. Conf. Rep. 101-596, 101st Cong., 2d Sess. 85, *reprinted in* 1990 U.S.C.C.A.N. 565, 594.

The Council's report *Toward Independence* contains a section called "The Population with Disabilities." That section examines surveys and estimates of the total disabled American population, citing examples and categories such as recent heart by-pass surgery, cerebral palsy, severe depression, blindness, spinal cord injuries, speech and hearing impairments. There are no examples or categories corresponding to those with specifically reproductive disorders. National Council on the Handicapped, *Toward Independence* 3-6 (Feb. 1986).[27] The Council's follow-up report

disabilities, and above all else, an absolute political desire to exclude certain classes of people no matter what the definition may be.

[27] A category such as "partially or completely paralyzed," *id.* at 6, includes people who cannot reproduce, but this is not a category corresponding to specifically reproductive disorders.

to Congress also examines surveys and estimates of the total disabled American population and likewise includes no examples or categories corresponding to those with specifically reproductive disorders. National Council on the Handicapped, *On the Threshold of Independence* 9-17 (Jan. 1988). Likewise, neither *Americans With Disabilities: 1991-1992* (Bureau of the Census 1993), nor *Disability In America* (National Academy Press 1991), include references or categories corresponding to persons with specifically reproductive disorders.[28]

C. The Regulatory History of the ADA, and Other Factors, Show That the ADA Does Not Contemplate Sexual Intercourse and Reproduction As Major Life Activities.

Neither sex nor reproduction is included in the Justice Department's regulatory list of major life activities. 28 C.F.R. § 36.104. This is not dispositive because the list does not purport to be exclusive. In light of the rule's history, however, their absence is so conspicuous that the Court should interpret the list as a reasonable conclusion by the Justice Department that "disability" under title III of the ADA should not be defined in terms of limits on specifically sexual or reproductive activity.

[28] The latter reports that "major activities" for defining disability in the 1988 National Health Interview Survey were "playing" for young children, "attending school" for older children, "working" or "keeping house" for adults, and "living independently" for senior citizens. *Id.* at 42.

More precisely, the Justice Department was familiar with the Kmiec Memorandum and the question of HIV as a disability. In its regulatory preamble the Department refers to both and follows HUD's lead by including "asymptomatic HIV disease" as one example of a physical impairment, but not a per se disability. 56 Fed. Reg. 35544, 35548 (July 26, 1991), *reprinted at* 28 C.F.R. Pt. 36, App. B § 104. On the next page, *id.* at 35549, the Department presents and explains its list of major life activities, but does not include reproduction, or a single one of the bundle of reproductive activities (intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations) named by the Appeals Court.

Obviously activities such as having sex, giving birth, changing diapers, and loving and educating one's children are activities of paramount importance to many Americans and in that sense are major life activities. This, in fact, is the Appeals Court's rationale for ruling that reproduction is a major life activity under the ADA. But it makes no sense, given the controversy surrounding HIV as a disability, the Kmiec Memorandum's reference to HIV-infected persons as substantially limited in the major life activities of "procreation and intimate personal relations," and the fact that reproductive activities are unmistakably part of everyday life for so many people (as Ms. Abbott will argue, the *sine qua non* of life itself), that the Justice Department would have meant to include sex and reproduction on its list of exemplar major life activities, but forgot or thought it was not worthy of explicit clarification.

Furthermore, the Justice Department's list of major life activities is taken verbatim from a list first formulated in regulations issued by HEW under the Rehabilitation Act, 42 Fed. Reg. 22676, 22678 (May 4, 1977). These regulations "were drafted with the oversight and approval of Congress." *Arline*, 480 U.S. at 279-80; *see Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 634 (1984). Ms. Abbott would have the Court conclude that although reproductive activities are the most fundamental of all life activities, and although Congress and federal agencies envisioned them as major life activities for defining "disability" under the Rehabilitation Act and the ADA, Congress, HEW, HUD, EEOC, and the Justice Department, after analyzing thousands of comments and participating in over twenty different hearings, all forgot to include reproductive activities in their respective lists of exemplar major life activities.

The more sensible conclusion for the Court is the obvious one: Although reproductive activities are of paramount importance in many persons' private, family lives, such activities are not what Congress envisioned as major life activities for defining disability under title III of the ADA, the goal of which is to integrate persons with disabilities into the mainstream of American civic life.[29]

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[29] Similar reasoning applies to "caring for others," or what the Appeals Court called "nurturing familial relations." (Pet. App. 7a). "Caring for one's self" has appeared on regulatory lists of exemplar major life activities since 1977, and any person reviewing such a list would have had to have considered

Including sexual intercourse and reproduction as major life activities for defining disability under the ADA also leads to some serious interpretive problems. For example, are post-menopausal women disabled? If not, is a post-menopausal woman who becomes infected with HIV disabled because of an inability to reproduce? Do we really think, or is it wise to think, that infertile women are disabled, or does this reinforce cultural stereotypes the ADA seeks to avoid? And what, really, does "reproduction" refer to? Does the Appeals Court really mean to suggest that sexual intercourse for the sake of procreation is a major life activity, because it is part of the bundle of reproductive activities, whereas sexual intercourse using a condom is not? Are men and women who undergo voluntary sterilization for family planning purposes "disabled"? A person who intentionally blinds himself is just as disabled as one who was accidentally blinded. So why would a person who was voluntarily sterilized not be disabled?

Some of these questions illustrate the important fact that reproductive activities, for human beings, are largely moral and lifestyle choices, in contrast to walking, seeing, hearing, speaking, and breathing. Many normal healthy adults choose not to have children, but they do not poke their eyes out. This fundamental dissimilarity has led the Eighth Circuit to the sensible conclusion that reproduction is not a major life activity for purposes of the ADA. *Krauel*

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whether "caring for others" should be on the list as well. The only reasonable conclusion is that several federal agencies decided it does not belong.

v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996); *see also Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995) (unlike other activities on the regulatory list, a person is not "called upon to reproduce throughout the day, every day," and treating reproduction as a major life activity under the ADA "would be a conscious expansion of the law . . . beyond the province of this Court"), *aff'd*, 79 F.3d 1143 (5th Cir. 1996).

An obvious retort is that "working" and "learning" are lifestyle choices for some, but they are major life activities under the ADA. These are easily distinguishable, however, in light of the manifest purposes of the ADA. The purpose of title I of the ADA is to promote gainful employment among the disabled, wherever reasonable, and one important purpose of title III is to expand private educational opportunities for the disabled, especially the mentally retarded, *see* 42 U.S.C. § 12181(7)(J). No similar purpose of title III warrants the inclusion of sex and reproduction as major life activities.

The Appeals Court cites *Stanley v. Illinois*, 405 U.S. 645 (1972), to illustrate the importance of reproductive activities in our society, and says that "our jurisprudence reflects this bias." (Pet. App. 7a) The Appeals Court is wrong to imply a judicial bias favoring reproduction, for our jurisprudence also supports the right *not* to reproduce. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Griswold v. Connecticut*, 381 U.S. 479 (1965).[30]

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[30] *Cf. Runnebaum*, 123 F.3d at 171 n.8 (agreeing that procreation is a fundamental human activity, skeptical that it

Ms. Abbott will also rely on the statement in a House Committee Report that "[a]s noted by the [Kmiec Memorandum], a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to *procreation and intimate sexual relationships.*" H. Rep. 101-485(II), 101st Cong., 2d Sess. 52, *reprinted in* 1990 U.S.C.C.A.N. 303, 334 (emphasis added).

This is the only manner in which the ADA's legislative history treats limitations on procreation and intimate sexual relationships as defining marks of disability. The reason such a statement appears in the Committee Report has nothing to do with addressing the concerns of impotent and infertile persons. The reason it is there is because of the controversy surrounding HIV as a disability. The words "procreation and intimate sexual relationships" appear in the legislative history *only* because they are part of the Kmiec Memorandum's unsupportable argument that all HIV-infected persons are actually disabled. For reasons previously stated, *supra* part II, pp. 19-27, the Court should not elevate such legislative history to the status of the statute on whether HIV is a per se disability. *Ipso facto* the Court should not give such history deciding weight on a different issue to which it is not even directed, namely, whether

is a major life activity contemplated by the ADA, and noting that the constitutionally protected status of an activity has little, if any, bearing on whether it is a major life activity contemplated by the ADA).

sexual activity and reproduction are major life activities generally.[31]

The basic dissimilarity between reproduction and the activities on agencies' illustrative lists of major life activities, Congressional approval of these lists, the meaning and examples of "disability" found in influential reports to Congress, and the purpose of title III of the ADA, which is to integrate persons with disabilities into the mainstream of American life, all lead to the conclusion that title III of the ADA does not envision sexual activity and reproduction as major life activities for the purpose of defining disability.

IV. EVEN IF REPRODUCTION WERE A MAJOR LIFE ACTIVITY UNDER THE ADA, AN ASYMPTOMATIC HIV-INFECTED WOMAN'S DECISION NOT TO REPRODUCE DOES NOT MAKE HER DISABLED.

Many asymptomatic women with HIV decide to become pregnant and have children, and most of their children are not infected with HIV. Many

[31] On related issues concerning the definition of disability, courts have ignored statements in the same Committee Report that are inconsistent with the plain language of the ADA. For example, the Report treats diabetes as a per se disability, and states that disability should be assessed without regard to medication. H. Rep. No. 101-485(II), 101st Cong., 2d Sess. 52 *reprinted in* 1990 U.S.C.C.A.N. 303, 334; *but see Wilking v. County of Ramsey*, ___ F. Supp. ___, ___, 1997 WL 694968, *3-*4 (D. Minn. 1997) (considering limitations in light of medication and citing cases); *Schluter v. Industrial Coils, Inc.*, 928 F. Supp. 1437, 1445 (W.D. Wis. 1996) (diabetes not a per se disability); *Deckert v. City of Ulysses*, 1995 WL 580074 (D. Kan. 1995) (same).

asymptomatic women with HIV decide not to have children. The difference between them is not physical, but decisions made according to their respective moral, religious, and cultural values. Physically, there is no substantial limitation on their abilities to reproduce, and therefore no disability under 42 U.S.C. § 12102(2)(A), which defines disability as a physical impairment (e.g., a spinal cord injury) that substantially limits a major life activity (e.g., walking). *See Runnebaum*, 123 F.3d at 172 (the "statutory language is plain: the impairment in question, not the individual's reaction to the impairment, must 'substantially limit[] one or more . . . major life activities").

Ms. Abbott may reply that HIV is an impairment that substantially limits reproduction in women who could have children, but decide not to, even if the link is psychological or moral, rather than physical. According to this argument, a link is no less real because it is psychological. One problem with this view is that physically identical people turn out to differ as to actual disability, which seems absurd. Another problem is that actual disability becomes a matter about which a woman can simply change her mind. That, too, seems absurd, compared to the view that actual disability is a lasting physical or mental phenomenon. *Cf.* 42 U.S.C. § 12101(a)(7) (disabling characteristics are "beyond the control" of persons with disabilities).

Another reply is that *all* asymptomatic women with HIV are substantially limited in the ability to reproduce, even those who have and care for healthy children, because all confront the risk of

perinatal transmission and their own uncertain life expectancies. This, however, empties the concept of "actual disability" of whatever meaning it had left. Women in abject poverty or violent neighborhoods confront in their reproductive decision-making risks just as significant that they and their babies will live short and miserable lives. Are they too actually disabled?[32] The more sensible view is that although many asymptomatic women with HIV decide not to have children because of significant risks and uncertainties, that does not make them actually disabled for purposes of the ADA.

V. EVEN IF REPRODUCTION WERE A MAJOR LIFE ACTIVITY, DR. BRAGDON CANNOT BE LIABLE IF THE REASON MS. ABBOTT IS DISABLED IS BECAUSE OF LIMITS ON HER ABILITY TO REPRODUCE.

Under title I of the ADA, an employer must know of an employee's disability for liability to attach. *E.g., Hedberg v. Indiana Bell Tel. Co., Inc.*, 47 F.3d 928, 932 (7th Cir. 1995). The same rule should apply under title III for private owners of public accommodations.

When Dr. Bragdon declined to fill Ms. Abbott's cavity in his office, he did not know Ms. Abbott's views about having children, e.g., whether she decided not to have children before she became

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[32] With advances in genetic science, more people will be identified who are carriers of defective genes that put them and their would-be offspring at risk for various disorders. Carriers of such genes are presently at risk for developing a disability, but they are not actually disabled.

infected, whether she still planned to have children, whether she decided not to have children after becoming infected, or whether she was physically infertile. Nor did her reproductive decision-making play any role in his decision-making. Thus, if Ms. Abbott's decision not to have children, rather than her HIV status alone, is the reason she is disabled, Dr. Bragdon cannot be liable under title III for discriminating against her "on the basis of disability." 42 U.S.C. § 12182(a).

VI. COURTS SHOULD DEFER TO PRIVATE HEALTH CARE PROVIDERS' INDIVIDUAL JUDGMENTS ABOUT DIRECT THREAT, AS LONG AS THEY ARE REASONABLE IN LIGHT OF THEN-CURRENT MEDICAL KNOWLEDGE.

A health care provider is not required by law to provide services to an individual who poses a direct threat to the health of others, including the health care provider. 42 U.S.C. § 12182(b)(3).[33] The words in the statute and its legislative history make clear that Congress intended to incorporate the direct threat standard from *Arline*. *E.g.*, H. Rep. No. 101-485(III), 101st Cong., 2d Sess. 34, 62 *reprinted in* 1990 U.S.C.C.A.N. 445, 457, 485. The Justice Department regulations effectuate this intent by specifying that in determining whether an individual poses a direct threat, a health care provider must make "an individualized assessment, based on *reasonable* judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the

[33] Many believe that Dr. Bragdon acted ethically, but many who do not would agree that liberal democracy depends on a distinction between moral and legal obligations.

nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk." 28 C.F.R. § 36.208(c) (emphasis added).

Based on the regulation's plain language, the lower courts should have inquired only as to whether, on September 16, 1994, Dr. Bragdon made a reasonable judgment based on then-current medical knowledge and pertinent individualized facts, that there would have been a direct threat to himself and/or others if he filled Ms. Abbott's cavity in his office. If Dr. Bragdon's judgment was reasonable, then regardless of what moral philosophers may say, or what was implicit (or even explicit) in conflicting private or public health guidelines, he had no legal obligation under title III of the ADA to fill the cavity in his office. This view comports with legislative history which states that "nothing in this legislation is intended to prohibit a physician from providing the most appropriate medical treatment *in the physician's judgment*." S. Rep. 101-116, 101st Cong., 1st Sess. 63 (1989) (emphasis added); *cf. Onishea v. Hopper*, 126 F.3d 1323, 1330 (11th Cir. 1997) (burden is on plaintiffs under § 504 to show that HIV infection poses no significant risk to others); *E.E.O.C. v. Amego, Inc.*, 110 F.3d 143 (1st Cir. 1997) (burden is on plaintiffs under title I to show they do not pose a significant risk to others).

The lower courts, however, injected a new policy twist into the analysis, based mostly on *Arline's* words that "courts normally should defer to the reasonable medical judgments of public

health officials." *Arline*, 480 U.S. at 288. For the District Court this meant Dr. Bragdon had to prove at summary judgment that a CDC official's after-the-fact affidavits were "medically unsupportable." For the Appeals Court this meant Dr. Bragdon had to overcome at summary judgment a presumption of the correctness of what "seemed implicit" in 1993 CDC Guidelines.

Arline, however, specifically states that it does not address whether courts should defer to reasonable medical judgments of private physicians. *Arline*, 480 U.S. at 288 n.18; *see Kohl by Kohl v. Woodhaven Learning Ctr.*, 865 F.2d 930, 938 (8th Cir. 1989), *cert. denied*, 493 U.S. 892 (1989). Indeed, the American Medical Association (AMA) *amicus* brief relied upon by the Court in *Arline*, 480 U.S. at 288, argues that federal courts "should not choose between conflicting medical judgments offered by plaintiff and defendant, if defendant recipient[] can demonstrate that the medical evidence upon which he relied was within the range of reasonableness, given then current medical knowledge." AMA Brief 20 n.16 (No. 85-1277)

There are good reasons why the Court should follow this advice from the AMA concerning deference to private professional judgments within a range of reasonableness given then-current medical knowledge.

First, as already indicated, the regulations and legislative history appear to require it.

Second, in a variety of contexts, the Court has applied a standard of review based on deference to reasonable professional judgment. For example, in *Youngberg v. Romeo*, 457 U.S. 307 (1982), the Court held that the exercise of professional judgment set the proper standard for determining whether a State had adequately protected the rights of an institutionalized mentally retarded person to safety and freedom from unreasonable restraint. In determining what is "reasonable" in this situation, "courts must show deference to the judgment exercised by a qualified professional." *Id.* at 322. Applying this standard, the court's responsibility is to make certain that professional judgment was in fact exercised, but "it is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id.* at 321.[34]

With respect to a student's property interest in continued enrollment, the Court again emphasized the importance of showing respect for professional judgment, and stated that the Court would not override the faculty's professional judgment "unless it is such a substantial departure from accepted academic norms as to demonstrate that the person or committee did not actually exercise professional judgment." *Regents of the University of Michigan v. Ewing*, 474 US 214, 225 (1985).[35]

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[34] The AMA's Principle VI of Medical Ethics is that a "physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." AMA, *Code of Medical Ethics* (1997).

[35] In reviewing a claim of ineffective assistance of counsel, the Court has stated that "judicial scrutiny of counsel's

In cases recognizing and confirming a woman's right to terminate a pregnancy, the Court has also recognized the importance of individual medical decisions and given deference to a physician's exercise of professional judgment. In *Roe v. Wade*, 410 U.S. 113, 163-65 (1972), the Court ruled that prior to the time when the state has a compelling interest in the pregnancy, the physician's medical judgment may be effectuated "free of interference from the State," and after that point, the state's interest may still be overridden by "appropriate medical judgment." In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 64-65 (1976), the Court observed that determination of viability should not be a function of the legislature or the courts but "rests with the physician in the exercise of his professional judgment." *Colautti v. Franklin*, 439 U.S. 379, 387-88 (1979), reaffirmed the role of professional judgment, based on the particular facts of each case, and repeated the "importance of affording the physician adequate discretion in the exercise of his medical judgment."[36]

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performance must be highly deferential," and the claimant must identify actions "that are alleged not to have been the result of reasonable professional judgment." *Strickland v. Washington*, 466 U.S. 668, 690 (1984); *see also Washington v. Harper*, 494 US 210, 232 (1990); *Goldman v. Weinberger*, 475 U.S. 503, 507 (1986).

[36] *See also United States v. Massachusetts*, 890 F.2d 507, 510 (1st Cir. 1989) ("The principle that, in cases where expertise is required, qualified professionals must be free to exercise their judgment within constitutional confines is firmly rooted in our jurisprudence."); *cf.* Susan M. Miltko, *The Need For Professional Discretion: Health Professionals Under the [ADA]*, 89 Nw. U. L. Rev. 1731 (1995).

Third, deference to government health officials is based on an ahistorical, doubtful assumption, that they, rather than private doctors are more likely right. It is less important in this regard to recall the specifics of *Buck v. Bell*, 274 U.S. 200 (1927), than the fact that what happened *seemed* right at the time to well-meaning intelligent members of the Court and public health authorities. The short-lived swine flu immunization program of 1976 is another illustration of the questionable assumption that government health officials are presumably correct.[37]

This does not mean private citizens are more often correct. It is only to remind the Court that when searching for what is right, it will often be comfortable to defer to well-meaning public officials. Historically, however, there is scant

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[37] The swine flu vaccine recommended by CDC had the unanticipated serious side-effect of significantly increasing the risk of developing Guillain-Barre syndrome (a sometimes fatal, ascending paralysis). Richard Neustadt & Harvey Fineberg, *The Swine Flu Affair* 73 (1978) (study published and commissioned by HEW); Arthur Silverstein, *Pure Politics & Impure Science: The Swine Flu Affair* 116-122 (1981). The risk of developing Guillain-Barre syndrome for vaccinees was still less than 1 in 100,000, but public health officials deemed this unacceptably high (i.e., very significant) in light of the unanticipated absence of swine flu among those not inoculated. The mass inoculation program was therefore abandoned. Neustadt & Fineberg, *supra*, at 1, 69-73; Silverstein, *supra*, 118-119. The HEW study blamed the fiasco on, *inter alia*, "overconfidence by specialists in theories spun from meagre evidence" and "conviction fueled by a conjunction of some preexisting personal agendas." Neustadt & Fineberg, *supra*, at 1.

justification for believing that this more often leads to what is right, and depending on who is in power, it can be positively dangerous. The safer and wiser thing to do is for courts to treat the opinions of government health officials like the opinions of other experts: neither presumably correct nor incorrect, but subject to vigorous cross-examination and presentation of contrary evidence according to the conventional devices of our adversary system. *Cf. Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 596 (1993) (rejecting "general acceptance" test for admissibility of scientific evidence and relying upon the ordinary tenets of the adversarial process); *Davis v. Meese*, 692 F. Supp. 505, 520 (E.D. Pa. 1988) (weighing competing expert opinions as to risk in § 504 case), *aff'd*, 865 F.2d 592 (3rd Cir. 1989) (per curiam).

Fourth, special deference to public health officials in litigation under title III is based on a misunderstanding of public health authority expertise, which is to study and make recommendations for *populations* not *individuals*. Their analyses subsume, rather than manifest, the particular facts according to which reasonable professional judgments must be made. In any given case, such facts may include the fact that this dentist is more clumsy and cuts himself more often, the fact that this cavity will require more and difficult drilling, or the fact that this patient is new and jittery.

Imagine a private physician in 1976 who decided not to take a swine flu shot because the vaccine had not been adequately tested, in his judgment. Should Congress have passed a law

compelling every person to take a shot unless he or she could overcome in court a presumption that CDC was correct in its initial analysis? One would think there would be a great deal of public debate preceding such legislation, and that courts would not easily imply such a rule where none was express. Yet, the District Court and Appeals Court did not hesitate to find implicit in the ADA a Congressional intent to compel dentists to take identifiable occupational risks, based on dimly articulated CDC policy analysis, even if individual professionals may reasonably believe such risks are significant.

Fifth, deference to public health officials is difficult when they disagree, which is not uncommon.[38] In this case, reasonable conflicting inferences may be drawn from OSHA, FDA, and CDC sources. (Pet. 13-17) In addition, is a school nurse entitled to the same degree of deference as OSHA regulations? Are private physicians who serve on advisory committees for public health organizations entitled to speak as public health officials? The more workable solution is to rely on the conventional devices of the adversarial system rather than *a priori* categories and presumptions.

Persons with disabilities should reasonably expect service unimpeded by false stereotypes and unfounded fears. When experts disagree as to the significance of the risk to dentists of providing a

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[38] *See, e.g.*, David Brown, *Institute Revises Advice On Mammograms in 40s*, Wash. Post, March 28, 1997, at A1 (reporting divergent views on regular mammograms for women in their forties); Neustadt & Fineberg, *supra* n.33, at 38-39.

service, but there is an identifiable risk which a reasonable dentist could deem personally significant, the law should not compel every qualified dentist to provide the service. Here is the space for civil liberty among dentists. Some will provide the service, some will not, and some will offer to do so with special precautions. Minimum CDC guidelines should not become maximum allowable precautions, and health care workers should not be discouraged from deferring non-emergency treatment to settings where maximum precautions may be taken.

CONCLUSION

WHEREFORE, the judgment of the Appeals Court should be reversed. The case should be remanded for entry of judgment in favor of Dr. Bragdon, or for further proceedings consistent with the opinion of the Court.

Respectfully submitted,

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APPENDIX

42 U.S.C. § 12102(2): "The term 'disability' means, with respect to an individual – (A) a physical or mental impairment that substantially limits one or more major life activities; (B) a record of such an impairment; or (C) being regarded as having such an impairment.

28 C.F.R. § 36.104: "The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

42 U.S.C. § 12182(b)(3): "**Specific Construction**. Nothing in this subchapter [title III of the ADA] shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."

28 C.F.R. § 36.208(c): "In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability

duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk."